

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

8855-63-037505
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

FILED SEP 27 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN
ST LOUIS

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY

c. CITY OR TOWN
ST LOUIS

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION
Cardinal Glennon Hosp

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
3215 Osceola

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First Middle Last
ROBERT EAVES EABES

4. DATE OF DEATH
Month Day Year
SEPT 2 1963

5. SEX

MALE

6. COLOR OR RACE
WHITE

7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH
2/2/62

9. AGE (last birthday)
1

IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None

10b. KIND OF BUSINESS OR INDUSTRY
None

11. BIRTHPLACE (City and state or country)
ST LOUIS MO

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

ROBERT EABES

13b. MOTHER'S MAIDEN NAME

Sylvia ROSE

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT
Address
ST VINCENT de PAUL SOCIETY LINDELL 4140

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

Fracture of the skull with hemorrhage of brain
through fractures of skull. Suffered in fall from
window of 2nd floor at 3215 Osceola on August 31, 1963.

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)
accident 902-0521

PART III. If deceased was female was
there a pregnancy in last 90 days.
☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE
A ☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
See above

20c. TIME OF INJURY
Hour a.m. p.m.
8-31-63

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☒

20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg, etc.)
Home 15

20f. CITY, TOWN, OR LOCATION
ST. Louis, MO

COUNTY STATE

21. I attended the deceased from _____ to _____ and last saw her
him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Helan L. Taylor, Coroner

22b. ADDRESS

1300 Clark Ave

22c. DATE SIGNED

9-3-63

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

9-3-63

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St. Louis

(State)

Mo

24. FUNERAL DIRECTOR

ADDRESS

Pullen & Kelly 7267 Natural Bridge

25. DATE RECD. BY LOCAL REG.

SEP 3 1963

REGISTRAR'S SIGNATURE

Paul Smith. M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Licensed Embalmer No. 4142

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.